STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G447	B. WING		11/12/2014	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R		(NOLLTON RD		
VOCA CO	ORPORATION OF	INDIANA	INDIANAPOLIS, IN 46228			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
W000000						
		or a fundamental annual	W000000			
	recertification as	nd state licensure survey.				
	Dates of Survey	: 11/5/14, 11/6/14,				
	11/10/14 and 11					
	11/10/11 and 11	/12/11				
	Essilita Namalasa	000061				
	Facility Number					
	Provider Numbe					
	AIMS Number:	100244750				
	Surveyor:					
	Keith Briner, Ql	IDP				
	, (					
	These deficienci	ies also reflect state				
	_	rdance with 460 IAC 9.				
	` .	completed 11/24/14 by				
	Ruth Shackelfor	rd, QIDP.				
W00040E	402 420/~\/2\					
W000125	483.420(a)(3)	F CLIENTS RIGHTS				
		ensure the rights of all				
		e, the facility must allow				
		dividual clients to exercise				
	_	ents of the facility, and as				
	citizens of the Un	ited States, including the				
	right to file compla	aints, and the right to due				
	process.					
		review and interview for	W000125		12/12/2014	
	4 of 4 sampled of	elients (#1, #2, #3 and		CORRECTION:		
	#4), the facility	failed to ensure clients		The facility must ensure the		
		4's individual rights were		rights of all clients. Therefore, the	ha	
		the facility's practice of		facility must allow and encourage		
	1	s to soda without due		individual clients to exercise their		
	135011001115 00005	5 to Some minioni due		rights as clients of the facility,		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447		A. BUILDING 00 COM		(X3) DATE SURVEY COMPLETED 11/12/2014	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	Process or assess Findings include Observations we group home on through 6:05 PM walked into the area where staff #2 stated, "Pop. "Not tonight." Of the living room #8 returned to the outing with her affast food cup wiff approached clien out toward the cup." Client #2 #8 left the area. Stood in the hall area and the dinarea and the dinarea to the top of the fast food cup of toward the cup as Staff #1 was integrated.	LSC IDENTIFYING INFORMATION) sed need.	TAG	and as citizens of the United States, including the right to file complaints, and the right to due process. Specifically for Clients #1, #2, #3 and #4, through assessment, the interdisciplinary team has determined that only one individual (Client #2) needs to have limited access to soft drinks for documented health reasons. The modification of this right will be incorporated into Client #2's support plan based of physician recommendations and after written informed consent from client #2's guardian and Human Rights Committee approval has been obtained. Through assessment, the team determined that this deficient practice affected 4 additional clients: #5, #6, #7 and #8. Access to soft drinks will not be limited for these individuals.  PERVENTION:  Staff will be retrained regarding the need to refrain from bringing personal items into the facility that could present a distraction skill acquisition and the active treatment process. These items will include but not be limited to large containers of snacks and	g tto
	CS #2 (Clinical interviewed on 1	Supervisor) was 1/6/14 at 2:15 PM, CS		soft drinks. The QIDP has been retrained regarding the need to	

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#2 indicated clients #1, #2, #3 and #4

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet

assure restrictive measures are

Page 2 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED
		15G447	A. BUII B. WIN			11/12/2014
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER				NOLLTON RD	
VOCA C	ORPORATION OF I	ΝΟΙΔΝΑ			APOLIS, IN 46228	
				INDIAN		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	could have diet s	soda if they choose.			implemented only when an	
					assessed need has been	
	1. Client #1's rec	ord was reviewed on			identified and informed consent	
	11/6/14 at 1:00 F	PM. Client #1's MIRF			has been obtained. The	
		Individual's Rights			Governing Body has added an additional layer of supervision at	
	`	7/13 indicated client #1			the facility to assist the QIDP wit	
	· · · · · · · · · · · · · · · · · · ·	ted from concentrated			focusing on support plan	"
					development and monitoring,	
		's MIRF dated 12/7/13			including but not limited to	
		client #1 should be			assessing client's need for	
		iet soda/sugar free soda			restrictive programs and their	
	options. Client #1's record did not				ability to give informed consent.	
	indicate document	ntation of client #1 being			Members of the Operations Tean	n
	assessed as need	ing to be restricted from			will review facility support	
	diet/sugar free so				documents no less than monthly	
		· ····································			to assure that accurate informed	
	2 Client #2's rec	ord was reviewed on			consent assessments are in place	
					and that prior written informed	
		AM. Client #2's MIRF			consent is obtained for all	
		dicated client #2 should			restrictive programs.	
		n concentrated sweets.				
	Client #2's MIRI	E dated 8/14/14 did not			RESPONSIBLE PARTIES:	
	indicate client #2	2 should be restricted			QIDP, Residential Manager,	
	from diet soda/su	agar free soda options.			Team Leader, Operations Tea	m
		d did not indicate				
	documentation o					
		ing to be restricted from				
	diet/sugar free so					
	uicusugai iiee so	oua options.				
	2 (1)					
		ord was reviewed on				
		PM. Client #3's MIRF				
	dated 11/14/13 in	ndicated client #3 should				
	be restricted from	n concentrated sweets.				
	Client #3's MIRI	E dated 11/14/13 did not				
	indicate client #3	3 should be restricted				
		agar free soda options.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet Page 3 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G447	B. WING		11/12/2014
	PROVIDER OR SUPPLIE		4114 K	ADDRESS, CITY, STATE, ZIP CODE NOLLTON RD IAPOLIS, IN 46228	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	DROUDERS N. AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	Client #3's recor	rd did not indicate			
	documentation of	of client #3 being			
	assessed as need	ling to be restricted from			
	diet/sugar free s	-			
	11/6/14 at 11:13 dated 11/21/13 ibe restricted from Client #4's MIR indicate client # from diet soda/s Client #4's record documentation of assessed as need diet/sugar free second client #4 was in 12:45 PM. When drink soda in he stated, "We do second content with the stated of the second content with the second conten	cord was reviewed on AM. Client #4's MIRF indicated client #4 should m concentrated sweets. F dated 11/21/13 did not 4 should be restricted ugar free soda options. Indicate of client #4 being ling to be restricted from indicate of client #4 being ling to be restricted from indicate of a sked if she was able to regroup home, client #4 sometimes. We had some the don't get it too often."			
W000149	483.420(d)(1) STAFF TREATM The facility must of written policies are mistreatment, nego Based on record 1 of 4 sampled of failed to implement	ENT OF CLIENTS develop and implement and procedures that prohibit glect or abuse of the client. I review and interview for clients (#3), the facility ment its policy and revent neglect of client #3	W000149	CORRECTION: The facility must develop and implement written policies and procedure that prohibit mistreatment, neg or abuse of the client. Specific	glect

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet

Page 4 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		15G447	A. BUIL B. WIN			11/12/2	2014
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L Company of the Comp			NOLLTON RD		
VOCA CO	ORPORATION OF	INDIANA	INDIANAPOLIS, IN 46228				
						<u> </u>	
(X4) ID		TATEMENT OF DEFICIENCIES		ID  PROVIDER'S PLAN OF CORRECTION  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	l `	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	٠٠٠	DATE
		gestion of psychotropic			The Residential Manager an members of the administrative		
		prescribed to her, conduct			investigation team have been	,	
	an investigation	regarding client #3's			retrained on components of a		
	ingestion of psyc	chotropic medication not			thorough investigation,		
	prescribed to her	and to develop and			specifically that all potential		
	_	ctive actions to prevent			witnesses must be interviewed		
	_	ditional ingestion of			Additionally, the manager and		
		dication not prescribed			investigative team have been		
	to her.	dication not prescribed			retrained regarding the need to review all relevant documents		
	to ner.				including but not limited to		
					progress notes and behavior		
	Findings include	<b>:</b> :			tracking as part of the		
					investigation process.		
	The facility's BD	DDS (Bureau of			Additionally, the Governing Bo	ody	
	Developmental I	Disabilities Services)			has revised the criteria for		
	_	stigations were reviewed			incidents requiring investigation		
		8 PM. The review			include events where staff cou	ıld	
	indicated the following				potentially have failed to implement safety protocols		
	indicated the for	lowing.			including but not limited to		
	DDDG 1	. 10/4/14: 1: 1			Comprehensive High Risk Pla	ns.	
	_	ated 8/4/14 indicated,			All supervisory staff will receiv		
	_	ned the medication room			training toward implementation	n of	
	door as staff was	s preparing medication			the revised policy. The facil	ity	
	for another indiv	ridual and grabbed the			will retrain all staff on the		
	medication cup	on the counter and took a			agency's medication		
	2 milligram Risr	peridone tablet. This			administration procedures including the need to keep the		
		not prescribed for [client			medication room locked at all		
		nd administrative staff			times and to assure once		
	-	this incident. The nurse			medications are prepared for		
					administration, they are kept of		
	_	call pharmacist and he			of reach of clients who may fo	rce	
		[client #3] her Seroquel			their way into the medication	.	
	tablet but she co	uld have all her other			room prior to being prompted	το	
	medication. [Cli	ent #3] will receive a late			take their medication.  PREVENTION: Investigations	of	
	dosage of the Se	roquel. The only side			allegations of abuse, neglect a		
		ated was possibly			mistreatment will undergo a	A110	
	_	f continued to monitor			formal peer review process to		
					•	I	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DING	00	COMPLETED	)
		15G447	A. BUI B. WIN	LDING		11/12/2014	1
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	₹			NOLLTON RD		
VOCA C	ORPORATION OF	INDIANA			IAPOLIS, IN 46228		
		INDIANA		INDIAN			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		MPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	[client #3] the re	emainder of the shift and			ensure the investigations are		
throughout the night."				thorough. The Peer Review To	eam		
					will be composed of administrative level staff include	ding	
	-The review did	not indicate			the Executive Director, Progra		
		of an investigation to			Manager, Clinical Supervisors		
		_			and a representative from the		
	describe and exp				Human Resources Departmen	nt.	
		elient #3's ingestion of her			Additionally, the Residential		
		ne 2 milligram tablet.			Manager will turn in copies of		
	The review did i	not indicate			completed internal facility		
	documentation of	of a finding of fact and			investigations to the Clinical		
	determination as	s to whether client #3's			Supervisor to allow for		
	rights were viola	ated, concerns and			appropriate oversight and follow-up. The Clinical Superv	isor	
	_	ns and methods to prevent			will follow-up with the Resider		
	future incidents.	•			Manager as needed but no les		
	Tuture incidents.				than weekly to review incident		
					documentation and completed		
		d was reviewed on			investigations to assure they h	ave	
	11/6/14 at 12:00	PM. Client #3's			been completed thoroughly.		
	physician's orde	r form dated 9/19/14 did			ADDENDUM, 12/21/14: The		
	not indicate clie	nt #3 should receive			Clinical Supervisor will prov		
	Risperidone 2 m	nilligrams			the Operations Team and fro	nt	
	rasperidone 2 in				line Supervisors with daily		
	CC (Climical Com	annigan) #1 yyaa			updates of incidents requirir investigation. These updates	_	
	CS (Clinical Sup				will be reviewed by both the	'	
		11/5/14 at 2:15 PM. CS			Program Manager and		
		facility's abuse and			Executive Director. The		
	neglect policy sl	nould be implemented.			Program Manager will provide	le	
	CS #1 indicated	allegations of abuse,			a weekly report to the		
	neglect, mistreat	tment and injuries of			Executive Director regarding		
	_	should be investigated.			the status of open		
		corrective action to			investigations at the facility	for	
		rence of abuse, neglect,			the purpose of holding the		
	1 *	, ,			QIDP and other team member	rs	
		injuries of unknown			accountable for completing		
		developed from the IDT			thorough investigations with	in	
	(Interdisciplinar	y Team) or from the			established timelines.	.	
	investigation nee	er review process			Completed abuse, neglect and	t	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G447	A. BUII B. WIN			11/12/	2014
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	t			NOLLTON RD		
VOCA C	ORPORATION OF	INDIANA			APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID			(V.5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
					mistreatment investigations wi		
	The facility's pol	licy and procedures were			be reviewed as part of a forma		
	reviewed on 11/10/14 at 3:45 PM. The				quarterly audit process. When		
		Neglect, Exploitation			deficiencies are noted, the	46.0	
	-	_			Executive Director will amend agency's Quality Improvement		
		at policy dated 2/26/11			Plan to correct and prevent fut		
		ram intervention neglect:			occurrences. The QIDP wil		
	_	e goods and/or services			bring all relevant elements of t		
		e individual to avoid			interdisciplinary team together		
		The 2/26/11 policy			after serious incidents includin but not limited to falls and	g	
		ical neglect: failure to			discovered injuries to review		
	provide goods and/or services necessary				current supports and to make		
	for the individua	ll to avoid physical harm.			adjustments and revisions as		
	Failure to provid	le necessary medical			needed. The QIDP will turn in		
	attention, proper	nutritional support or			copies of post-incident		
	administering m	edications as prescribed."			interdisciplinary team meeting notes to the Program Manage	-	
		•			and Clinical Supervisor to allow		
	The facility's Inv	vestigations policy dated			for appropriate oversight and	•	
	_	d, "In order to ensure the			follow-up. The Clinical Supervi	isor	
		d welfare of the people			will meet weekly with the QIDF		
	-	nts or collections of			review incidents which require		
	* * *	at are outside of what is			interdisciplinary team action. The Residential Manager will l	20	
					expected to observe no less th		
		ed, cannot by (sic)			one morning and one evening		
	explained and ur				active treatment session per		
		event and result in or			week and the Team Leader wi	II	
	•	al to result in injury or			be required to observe and		
		r exploitation to the			participate in active treatment sessions on varied shifts no le	ss	
		be investigated." The			than five times per week. During		
	9/14/07 policy in	ndicated investigations			Active Treatment observations	•	
	should include "	Finding of fact and			supervisors will assess direct		
	determination as	to whether or not the			support staff interaction with	<b>-</b>	
	allegations are si	ubstantiated,			clients and to provide hands o coaching and training including		
	unsubstantiated	or inconclusive.			but not limited to assuring staf		
	Concerns and re-	commendations			follow medication administration		
	Methods to prev	ent future incidents."			procedures and implement		
	1		1				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/31/2014 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:  15G447	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 11/12/2014		
	PROVIDER OR SUPPLIER  ORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	9-3-2(a)		behavior supports and safety protocols. Additionally, member of the Operations Team and the QIDP will conduct active treatment observations on a weekly basis for the next 30 disproviding hands-on coaching a training as needed. After two months, The Operations team and QIDP will observe active treatment sessions no less that every two weeks for an addition 60 days. After 90 days, the Operations Team will review incident data and observational assessments to determine the need for ongoing oversight, with the goal of scaling back the administrative presence in the home to no less than monthly. <b>RESPONSIBLE PARTIES:</b> QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	ays, and an onal		
W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 3 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed, the facility failed to conduct an investigation regarding client #3's ingestion of psychotropic medication not prescribed to her.  Findings include:	W000154	CORRECTION: The facility must have evidence that all alleged violations are thorough investigated. Specifically, the Residential Manager and members of the administrative investigation team have been retrained on components of a thorough investigation, specifically that all potential witnesses must be interviewed Additionally, the manager and	d.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet

Page 8 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLETED
		15G447	B. WIN			11/12/2014
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER					
VOCA C		NIDLANIA			NOLLTON RD	
VOCA CO	ORPORATION OF I	NDIANA		INDIAN	APOLIS, IN 46228	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	The facility's BD	DDS (Bureau of			investigative team have been	
	1	Disabilities Services)			retrained regarding the need to	
		stigations were reviewed			review all relevant documents	
	_	•			including but not limited to	
		8 PM. The review			progress notes and behavior	
	indicated the foll	lowing:			tracking as part of the	
					investigation process.  Additionally, the Governing Bo	dv
	-BDDS report da	ated 8/4/14 indicated,			has revised the criteria for	ч
	"[Client #3] oper	ned the medication room			incidents requiring investigation	n to
		preparing medication			include events where staff cou	
		idual and grabbed the			potentially have failed to	
		_			implement safety protocols	
	_	on the counter and took a			including but not limited to	
	-	peridone tablet. This			Comprehensive High Risk Pla	
	medication was i	not prescribed for [client			All supervisory staff will receive	
	#3]. The nurse ar	nd administrative staff			training toward implementation	
	-	this incident. The nurse			the revised policy.PREVENTION	
		all pharmacist and he			Investigations of allegations of	
	_	•			abuse, neglect and mistreatme	
		client #3] her Seroquel			will undergo a formal peer revi process to ensure the	ew
		uld have all her other			investigations are thorough. The	ne
	medication. [Client	ent #3] will receive a late			Peer Review Team will be	
	dosage of the Ser	roquel. The only side			composed of administrative lev	vel
	effect he anticipa	ated was possibly			staff including the Executive	
	_	f continued to monitor			Director, Program Manager,	
					Clinical Supervisors and a	
	-	mainder of the shift and			representative from the Humai	n
	throughout the n	ignt."			Resources Department.	
					Additionally, the Residential	
	-The review did:	not indicate			Manager will turn in copies of	
	documentation o	f an investigation to			completed internal facility	
	describe and exp				investigations to the Clinical Supervisor to allow for	
	_	lient #3's ingestion of her			appropriate oversight and	
		· ·			follow-up. The Clinical Supervi	sor
	1 ^	ne 2 milligram tablet.			will follow-up with the Residen	
	The review did n				Manager as needed but no les	
	documentation o	f a finding of fact and			than weekly to review incident	
	determination as	to whether client #3's			documentation and completed	
	rights were viola	ted.			investigations to assure they h	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet Page 9 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G447	B. WING		11/12/2014	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	11/6/14 at 12:00 physician's orde not indicate clier Risperidone 2 m  CS (Clinical Surinterviewed on 1 #1 indicated alle	r form dated 9/19/14 did nt #3 should receive illigrams.  pervisor) #1 was 1/5/14 at 2:15 PM. CS egations of abuse, neglect, d injuries of unknown		been completed thoroughly.  ADDENDUM, 12/21/14: The Clinical Supervisor will provi the Operations Team and fro line Supervisors with daily updates of incidents requirin investigation. These updates will be reviewed by both the Program Manager and Executive Director. The Program Manager will provid a weekly report to the Executive Director regarding the status of open investigations at the facility of the purpose of holding the QIDP and other team member accountable for completing thorough investigations with established timelines. Completed abuse, neglect and mistreatment investigations with established timelines. Completed abuse, neglect and mistreatment investigations with established timelines. Responsible plan to correct and prevent fut occurrences. Responsible PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Tea	nt g de for rs in d ll the ture LE	
W000157	If the alleged viola corrective action r Based on record 1 of 3 allegation	ENT OF CLIENTS ation is verified, appropriate must be taken. review and interview for s of abuse, neglect, d injuries of unknown	W000157	CORRECTION: If the alleged violation is verified, appropriate corrective action must be take Specifically, the facility will retr	e n.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet Page 10 of 39

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 15G447 11/12/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4114 KNOLLTON RD VOCA CORPORATION OF INDIANA INDIANAPOLIS, IN 46228 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE  $\mathsf{TAG}$ all staff on the agency's origin reviewed, the facility failed to medication administration develop and implement corrective actions procedures including the need to to prevent client #3 from additional keep the medication room locked ingestion of psychotropic medication not at all times and to assure once prescribed to her. medications are prepared for administration, they are kept out of reach of clients who may force Findings include: their way into the medication room prior to being prompted to The facility's BDDS (Bureau of take their medication. **PREVENTION:** The QIDP will Developmental Disabilities Services) bring all relevant elements of the reports and investigations were reviewed interdisciplinary team together on 11/5/14 at 2:18 PM. The review after serious incidents including but not limited to falls and indicated the following: discovered injuries to review current supports and to make -BDDS report dated 8/4/14 indicated, adjustments and revisions as "[Client #3] opened the medication room needed. The QIDP will turn in door as staff was preparing medication copies of post-incident interdisciplinary team meeting for another individual and grabbed the notes to the Program Manager medication cup on the counter and took a and Clinical Supervisor to allow 2 milligram Risperidone tablet. This for appropriate oversight and medication was not prescribed for [client follow-up. The Clinical Supervisor will meet weekly with the QIDP to #3]. The nurse and administrative staff review incidents which require were notified of this incident. The nurse interdisciplinary team action. spoke to the on call pharmacist and he The Residential Manager will be said to not give [client #3] her Seroquel expected to observe no less than one morning and one evening tablet but she could have all her other active treatment session per medication. [Client #3] will receive a late week and the Team Leader will dosage of the Seroquel. The only side be required to observe and effect he anticipated was possibly participate in active treatment sessions on varied shifts no less drowsiness. Staff continued to monitor than five times per week. During [client #3] the remainder of the shift and Active Treatment observations,

FORM CMS-2567(02-99) Previous Versions Obsolete

throughout the night."

-The review did not indicate

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet

supervisors will assess direct support staff interaction with clients and to provide hands on

Page 11 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G447	B. WING		11/12/2014
NAME OF B	PROVIDER OR SUPPLIE			ADDRESS, CITY, STATE, ZIP CODE	
				NOLLTON RD	
VOCA CO	ORPORATION OF	INDIANA	INDIAN	IAPOLIS, IN 46228	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	*	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)	TE COMPLETION DATE
1110	documentation	· · · · · · · · · · · · · · · · · · ·	1.10	coaching and training including	
		ns and methods to prevent		but not limited to assuring staf	
	future incidents.			follow medication administration procedures and implement	on
				behavior supports and safety	
		rd was reviewed on		protocols. Additionally, member	
		PM. Client #3's		of the Operations Team and the QIDP will conduct active	ie
		r form dated 9/19/14 did		treatment observations on a	
		nt #3 should receive		weekly basis for the next 30 day providing hands-on coaching a	
	•	nilligrams. Client #3's andicate documentation of		training as needed. <b>ADDENDU</b>	
		llinary Team) review of		12/21/14: After one month, TI	пе
	the 8/4/14 incide			Operations team and QIDP w	ill
		ns to prevent recurrence.		observe active treatment sessions no less than every	
	CS (Clinical Sujinterviewed on #1 indicated correoccurrence of mistreatment or origin should be or from the investment of process.	pervisor) #1 was 11/5/14 at 2:15 PM. CS rective action to prevent		two weeks on an ongoing basis. RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team, Operations Team	
	9-3-2(a)				
W000159	PROFESSIONAL Each client's activ be integrated, cod a qualified menta Based on observ	TAL RETARDATION  we treatment program must profinated and monitored by tretardation professional. The varion, record review and pof 4 sampled clients (#1,	W000159	CORRECTION: Each client's active treatment program mus	12/12/2011
	#2, #3 and #4), 1	the QIDP (Qualified		integrated, coordinated and monitored by a qualified menta	al

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	DDIC	00	COMPL	ETED
		15G447	A. BUIL B. WING			11/12/	2014
			D. WING	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			NOLLTON RD		
VOCA C	ORPORATION OF	INIDIANA			IAPOLIS, IN 46228		
VOCAC	URPURATION OF	INDIANA		INDIAN	IAPOLIS, IN 40226		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Intellectual Disa	abilities Professional)			retardation professional.		
	failed to integra	te, coordinate and			Specifically: The QIDP will		
	monitor clients	#1, #2, #3 and #4's active			retrained regarding the need to monitor clients' active treatme		
	treatment progra				programs for progression and		
		ression of skills, ensure			regression. A review of		
					documentation indicated this		
		ith client #2 were trained			deficient practice affected all		
	~ ~	#2's dietary orders,			clients residing in the facility.		
		's guardian participated in			The team has obtained		
	the developmen	t of her ISP (Individual			clarification regarding the		
	Support Plan), e	ensure the facility			appropriate modified texture of		
	provided aggres	sive implementation of			Client #2's diet and will train a	III	
	1 20	e treatment program,			staff toward proper implementation of the prescrit	had	
	ensure the facility's HRC (Human Rights				diet. A review of dietary	ocu	
		iewed and approved			recommendations indicated th	nis	
	· · · · · · · · · · · · · · · · · · ·	* *			deficient practice affected one	;	
	client #1's use o				additional individual –Client #	5.	
		ore-sedation for dental			Staff will also be trained toward	rd	
	procedures, ensi	ure the facility's HRC			proper implementation of this		
	obtained the wri	itten informed consent of			prescribed diet. The QIDP		
	clients #1 and #2	2's guardians regarding			be retrained regarding the new to bring all elements of the	ea	
	the use of psych	otropic medication for			interdisciplinary team includin	a	
		ement and ensure the			guardian and family members	-	
	_	the facility's practice of			assist with the development of		
					individual support plans. A rev	/iew	
	1	ts #1, #2, #3 and #4 from			of support documents indicate	ed	
	soda.				this deficient practice did not		
					affect any additional clients. T		
	Findings include	e:			QIDP will review Client #2's p		
					with the guardian, obtain appr for current supports and make		
	1. Client #1's red	cord was reviewed on			modifications per guardian inp		
	11/6/14 at 1:00 l	PM. Client #1's QIDP			applicable. The QIDP will		
		form dated 7/1/14			facilitate retraining of all direct	t	
	1	DP had reviewed client			support staff regarding the ne		
	#1's formal ISP				to provide consistent, aggress		
		·			and continuous active treatme		
		ression of skills. Client			for Client #3 including but not		
	#1's record did r	not indicate			limited to offering options for		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet Page 13 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED
		15G447				11/12/2014
			B. WIN		ADDRESS STATE STATE SOLD	
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE	
					NOLLTON RD	
VOCA CO	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46228	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	documentation of	of QIDP review of client			appropriate activities at freque	nt
	#1's progression/regression of ISP				intervals and training toward	
		res/skills since 7/1/14.			prioritized learning objectives	per
	l training objectiv	es/skins since //1/14.			the implementation schedule.	
					Administrative Team observat	
	2. Client #2's red	cord was reviewed on			of active treatment determined	
	11/6/14 at 9:36	AM. Client #2's QIDP			that this deficient practice did	
	monthly review	form dated 7/1/14			affect additional clients. The	
		DP had reviewed client			facility has located documenta	UON
	-				of approval from the Human Rights Committee for Client #	1'o
	#2's formal ISP	•			use of psychotropic medication	l l
	1	ression of skills. Client			for pre-sedation for dental	'
	#2's record did not indicate				procedures. For Clients #1,	#2
	documentation of	of QIDP review of client			#3 and #4, through assessme	•
	#2's progression	/regression of ISP			the interdisciplinary team has	,
		res/skills since 7/1/14.			determined that only one	
	l training objectiv	CS/SKIIIS SHICE //1/14.			individual (Client #2) needs to	
					have limited access to soft drii	nks
	3. Client #3's red	cord was reviewed on			for documented health reason	S.
	11/6/14 at 12:00	PM. Client #3's QIDP			The modification of this right w	<i>i</i> ill
	monthly review	form dated 7/1/14			be incorporated into Client #2'	
		DP had reviewed client			support plan based on physici	an
	#3's formal ISP				recommendations and after	
					written informed consent from	l l
		ression of skills. Client			client #2's guardian and Huma	
	#3's record did n				Rights Committee approval habeen obtained. Through	ю
	documentation of	of QIDP review of client			assessment, the team	
	#3's progression	/regression of ISP			determined that this deficient	
		res/skills since 7/1/14.			practice affected 4 additional	
	l daming objectiv				clients: #5, #6, #7 and #9. Acc	ess
	4 Client //41				to soft drinks will not be limited	
		cord was reviewed on			these individuals.	
	11/6/14 at 11:13 AM. Client #4's QIDP monthly review form dated 7/1/14 indicated the QIDP had reviewed client #4's formal ISP objectives for progression/regression of skills. Client				PERVENTION: The Governin	g
					Body has added an additional	
					layer of supervision at the faci	
					to assist the QIDP with focusing	_
					on support plan development	and
					monitoring. The Clinical	
	#4's record did n				Supervisor and Program Mana	
	L documentation of	of OIDP review of client			will review Individual Support	Plan ∣

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		15G447	B. WIN		11/12/2014		
		1	F II.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8		1	NOLLTON RD		
	ORPORATION OF			INDIANAPOLIS, IN 46228			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
		regression of ISP			Summaries no less that month	nly	
training objectives/skills since 7/1/14.				to assure the QIDP monitors clients for progression and			
					regression and modifies plans		
	CS #2 (Clinical Supervisor) was				accordingly. The Residentia		
	`	1/6/14 at 2:15 PM. CS			Manager will be expected to		
		re was not additional			observe no less than one mor	ning	
					and one evening active treatm		
		of QIDP review of clients			session per week and the Tea		
		s ISP training objectives.			Leader will be required to obs		
		the QIDP should review			and participate in active treatnessions on varied shifts no le		
	clients #1, #2, #3	3 and #4's training			than five times per week. Duri		
	objectives on a r	nonthly basis and make			Active Treatment observations	- I	
	revisions to goal	s based on			supervisors will assess direct	,	
	progression/regr	ession of skills.			support staff interaction with		
	1 1 1 2 1 1 1 1 2				clients and to provide hands o	n	
	5 The OIDD foi	led to ensure staff			coaching and training includin	- I	
	-				but not limited to assuring staf	f	
	_	ent #2 were trained			provide continuous active		
		#2's dietary orders.			treatment to all clients, follow		
	Please see W189	).	medication administration procedures, implement behavior			ior	
					supports and safety protocols		
	6. The QIDP fai	led to ensure client #2's			implement prescribed diets.		
	guardian particit	pated in the development		Additionally, members of the			
	of her ISP. Pleas				Operations Team and the QID	P	
		- · · · · <del>-</del>			will conduct active treatment		
	7 The OIDD foi	led to ensure the facility			observations on a weekly bas		
					for the next 30 days, providing		
		sive implementation of			hands-on coaching and trainir as needed. ADDENDUM,	ıy	
		e treatment program.			12/21/14: After one month, T	he	
	Please see W249	).			Operations Team and QIDP v		
					observe active treatment		
	8. The QIDP fai	led to ensure the facility's			sessions and review		
	HRC reviewed a	and approved client #1's			documentation no less than		
		pic medication for			every two weeks. The		
		dental procedures. Please			Operations Team will mainta	in	
		demai procedures. I rease			no less than a twice monthly	,	
	see W262.				presence in the home on an		
					ongoing basis, to assure tha	t	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE C			ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		15G447			11/12/2014		
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
1/001.0		INIDIANIA			NOLLTON RD		
VOCA CO	VOCA CORPORATION OF INDIANA			INDIAN	APOLIS, IN 46228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
	8 The OIDP fai	led to ensure the facility's			the QIDP integrates,		
	7	ne written informed			coordinates and monitors all		
					aspects of the active treatme	ent	
	consent of clients #1 and #2's guardians				process.The QIDP will turn in		
	regarding the use of psychotropic				documentation of family/guard	lian	
	medication for b	ehavior management.			communication to the Program		
	Please see W263	3.			Manager monthly. The Progra		
					Manager will in turn follow-up		
	9. The QIDP failed to ensure the HRC				assure that family members a	nd	
	`				guardians are invited and		
		eility's practice of			encouraged to participate in th		
	restricting client	s #1, #2, #3 and #4 from				Γhe	
	soda. Please see	W264.			QIDP will be retrained regarding	ng	
					the need to assure that the		
	9-3-3(a)				Human Rights Committee		
	)-3-3(a)				engages in a dialog to reach decisions regarding restrictive		
					programs for all clients. The		
					QIDP, facility nurse and Huma	ın	
					Rights Committee liaison will		
					each maintain copies of Huma	ın	
					rights Committee approval for		
					to assure the ability to reprodu		
					copies of HRC records for		
					surveyors upon request. The		
					agency has established a		
					quarterly system of internal au	dits	
					that review all facility systems		
					including, but not limited to, du	ıe	
					process and prior written		
					informed consent. Administrat	ive	
					staff will conduct visits to the	_	
					facility on a bi-weekly basis for		
					the next 30 days. ADDENDUM		
					12/21/14: After one month, TI		
					Operations Team and QIDP v	VIII	
					observe active treatment		
					sessions and review		
					documentation no less than		
					every two weeks. The		
					Operations Team will mainta		
					no less than a twice monthly		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet

Page 16 of 39

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/31/2014 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 11/12/2014		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION (X5) D BE COMPLETION DATE		
W000189	483.430(e)(1)			presence in the home on ongoing basis, to assure the QIDP integrates, coordinates and monitor aspects of the active treat process. The Program Mawill incorporate monitoring annual HRC approvals of restrictive programs into the current tracking process. QIDP will be retrained registed the need to obtain prior with informed consent from gual advocates and healthcare representatives for all rest programs prior to implement Retraining will focus on as that the QIDP has a clear understanding of what speconstitutes a restrictive program modificially program modificially program modificially program and other legal representatives. Prior to grapproval to restrictive program for the Human Rights Commit obtain confirmation that the facility has received prior winformed consent from gual or other legal representation that the agency has established quarterly system of international traces and prior written informed consent.  RESPONSIBLE PARTIES QIDP, Residential Management Leader, Direct Suppostaff, Operations Team	s all atment anager of The arding ritten ardians, rictive entation. esuring ecifically ogram fications ranting grams, attee will e written ardians ves. ed a al audits ems o due  : er,		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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Facility ID: 000961

If continuation sheet

Page 17 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		15G447	B. WIN			11/12/	/2014
		<u> </u>	B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			NOLLTON RD		
VOCA C	ORPORATION OF	ΙΝΠΙΛΝΑ			IAPOLIS, IN 46228		
					171 0010, 111 40220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRE			(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	STAFF TRAINING						
		provide each employee ntinuing training that					
		oyee to perform his or her					
	duties effectively,						
	competently.	omolonay, and					
		vation, record review and	- wo	00189	CORRECTION: The facility m	ust	12/12/2014
		of 4 sampled clients (#2),			provide each employee with initial		
		d to ensure staff working			and continuing training that		
	1	•			enables the employee to perfo	orm	
	with client #2 were trained regarding				his or her duties effectively,		
	client #2's dietar	y orders.			efficiently, and competently.		
					Specifically, the team has obtained clarification regarding	~	
	Findings include:				the appropriate modified textu		
					of Client #2's diet and will train		
	RM (Resident M	(Ianager) #1 was			staff toward proper		
	`	11/5/14 at 5:53 PM.			implementation of the prescrib	ed	
	When asked whi				diet. A review of dietary		
		orders, i.e. mechanical			recommendations indicated th	_	
	_				deficient practice affected one		
		ck liquids, RM #1 stated,			additional individual –Client #	_	
		nechanical soft. Everyone			Staff will also be trained towar proper implementation of this	u	
	else is regular. [0	Client #6] is the only			prescribed diet. PREVENTIO	N·	
	one."				The Residential Manager will		
					expected to observe no less th		
	Observations we	ere conducted at the			one morning and one evening		
		11/5/14 from 5:00 PM			active treatment session per		
		1. At 6:04 PM, client #2			week and the Team Leader w	ill	
	_	· ·			be required to observe and		
		ne group home's family			participate in active treatment sessions on varied shifts no le		
		eal. Client #2 ate pizza			than five times per week. Duri		
		t #2's food was not			Active Treatment observations	-	
	chopped or mech	hanical soft.			supervisors will assess direct		
					support staff interaction with		
	Client #2's recor	rd was reviewed on			clients and to provide hands o		
	11/6/14 at 9:36	AM. Client #2's Record			coaching and training including	-	
		form dated 6/21/12			but not limited to assuring staf	f	
	` ′	#2 should have a			implement prescribed diets.		
	i muicateu chent	#∠ SHOUIU Have a	1		Additionally, members of the		I

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  COMPLETED				
ANDILAN	15G447	A. BUILDING	00	11/12/2014		
	100447	B. WING	A DADAGO CAMAN COMA COMA	11/12/2014		
NAME OF P	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD				
VOCA CO	ORPORATION OF INDIANA	INDIANAPOLIS, IN 46228				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	DROWING DEAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	mechanical soft diet to prevent choking.		Operations Team and the QID	P		
	Client #2's Comprehensive High Risk		will conduct active treatment observations on a weekly basi	ie l		
	Health Plan (CHRHP) dated 7/7/14		for the next 30 days, providing			
	indicated, "Follow mechanical soft with		hands-on coaching and training			
	thin liquids 5 milliliter control flow cup		as needed. ADDENDUM,			
	guidelines at all times."		12/21/14: After one month, TI			
			Operations Team and QIDP v	vill		
	CS (Clinical Supervisor) #2 was		observe active treatment sessions and review			
	interviewed on 11/6/14 at 2:15 PM. CS		documentation no less than			
	#2 indicated RM #1 should know client		every two weeks. The			
#2's dietary orders and ensure staff working with client #2 were trained to			Operations Team will mainta	in		
			no less than a twice monthly	,		
	implement the orders.		presence in the home on an			
			ongoing basis, to assure tha the QIDP integrates,	t		
	9-3-3(a)		coordinates and monitors all			
	) 5 5 (u)		aspects of the active treatme			
			process. RESPONSIBLE			
			PARTIES: QIDP, Residential			
			Manager, Team Leader, Direc			
			Support Staff, Operations Tea	m		
W000209	483.440(c)(2)					
	INDIVIDUAL PROGRAM PLAN					
	Participation by the client, his or her parent					
	(if the client is a minor), or the client's legal					
	guardian is required unless the participation is unobtainable or inappropriate.					
	Based on record review and interview for	W000209		12/12/2014		
	1 of 4 sampled clients (#2), the facility	11000209	CORRECTION:	12/12/2014		
	failed to ensure client #2's guardian					
	participated in the development of her		Participation by the client, his or			
	ISP (Individual Support Plan).		her parent (if the client is a			
	101 (marviduai oupport i iaii).		minor), or the client's legal guardian is required unless the			
	Findings include:		participation is unobtainable or			
	rmanigs include.		inappropriate. Specifically for			
	Client #21a magand rayon marriant day		Client #2 the QIDP and			
	Client #2's record was reviewed on		Residential Manager will be			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet

Page 19 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE				
		15G447	B. WIN			11/12/	2014
MANGOTT	NOTABLE OF GLASS ASS			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF P	PROVIDER OR SUPPLIER			4114 KN	NOLLTON RD		
	ORPORATION OF I				APOLIS, IN 46228		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
		AM. Client #2's ISP			retrained regarding the need to		
	dated 8/14/14 indicated client #2 had a				bring all elements of the interdisciplinary team including		
		lient #2's ISP did not			guardian and family members, to	1	
	indicate docume	ntation of client #2's			assist with the development of	,	
	guardian's signature/participation in				individual support plans. A review	N	
	completing client #2's ISP. Client #2's				of support documents indicated		
	PCP (Person Centered Planning) form				this deficient practice did not		
	dated 8/14/14 did not indicate				affect any additional clients. The		
		f client #2's guardian's			QIDP will review Client #2's plan	1	
	signature/participation in the planning of				with the guardian, obtain		
	client #2's ISP.				approval for current supports an		
	CHCHt π2 5 151 .				make modifications per guardian input if applicable. A review of	l	
	OG (OI::::1.0				facility support documents		
	CS (Clinical Sup	· · · · · · · · · · · · · · · · · · ·			indicated this deficient practice		
		1/6/14 at 2:15 PM. CS			did not affect additional clients.		
		e was not additional					
		f client #2's guardian's					
	participation in t	he development and					
	planning of clien	t #2's ISP.			PERVENTION:		
	0.2.4(-)				The Governing Body has added		
	9-3-4(a)		an additional layer of supervision			า	
					at the facility to assist the QIDP		
					with focusing on support plan	_	
					development and monitoring. The	ie	
					QIDP will turn in documentation of family/guardian communication	nn .	
					to the Program Manager monthly		
					The Program Manager will in turn	•	
					follow-up to assure that family		
					members and guardians are		
					invited and encouraged to		
					participate in the ISP		
					development process.		
					RESPONSIBLE PARTIES:		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet

Page 20 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	a. BUILDING 00			COMPLETED	
		15G447	B. WING			11/12/2	2014	
NAME OF B	DOLUMBER OR GUIRRU IER		ST	TREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER		4114 KNOLLTON RD					
VOCA CO	ORPORATION OF I	NDIANA	INDIANAPOLIS, IN 46228					
(X4) ID		FATEMENT OF DEFICIENCIES	I	ID PROVIDER'S PLAN			(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PRE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	AG	<u> </u>		DATE	
					QIDP, Residential Manager, Team Leader, Direct Support			
					Staff, Operations Team			
					ctan, operations ream			
W000249	483.440(d)(1)			İ				
	PROGRAM IMPLE							
		erdisciplinary team has						
		t's individual program plan, eceive a continuous active						
		consisting of needed						
		services in sufficient						
		ency to support the						
		e objectives identified in						
	the individual prog	•	11/0002		CORRECTION: As soon as to	ha	12/12/2014	
		ation, record review and	W0002	49	interdisciplinary team has	ne	12/12/2014	
		f 4 sampled clients (#3),			formulated a client's individual	,		
	_	I to provide aggressive			program plan, each client mus			
	implementation of	of client #3's active			receive a continuous active			
	treatment program	m.			treatment program consisting	of		
					needed interventions and	and .		
	Findings include	:			services in sufficient number a frequency to support the	ina		
					achievement of the objectives			
	Observations we	re conducted at the			identified in the individual			
	group home on 1	1/5/14 from 5:00 PM			program plan. Specifically, all			
	through 6:00 PM	I. Client #3 was observed			direct support staff will be			
		bservation period. Client			retrained regarding the need to			
		er bedroom, to the			provide consistent, aggressive and continuous active treatme			
	•	ving room area and			for Client #3 including but not			
	· ·	er bedroom from 5:00			limited to offering options for			
		5 PM. Client #3 repeated			appropriate activities at freque	nt		
	_	ne and did not engage in			intervals and training toward			
		, socializing with her			prioritized learning objectives puthe implementation schedule.	pei		
		_			Administrative Team observati	ion		
		ate in the group home's			of active treatment determined	I		
		lient #3 was not coached			that this deficient practice did	not		
		oin or participate in the			affect additional clients.			
		At 5:45 PM, client #3			PREVENTION: The Residenti	iai		
	ioined her peers	in the dining area for the	1		Manager will be expected to			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet

Page 21 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) N			(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED	
		15G447	A. BUII B. WIN			11/12/2014	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER						
V004 0		NIDIANIA			NOLLTON RD		
VOCA CO	ORPORATION OF I	NDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	home's family st	yle evening meal.			observe no less than one morr	·	
		·			and one evening active treatm		
	Observations were conducted at the				session per week and the Tea		
					Leader will be required to obse		
	1	1/6/14 from 6:15 AM			and participate in active treatm		
	_	I. Client #3 paced from			sessions on varied shifts no le	SS	
	her bedroom, to	the kitchen, to the living			than five times per week. The QIDP will also maintain an		
	room area and re	turned to the her			ongoing presence at the facility	v.	
	bedroom from 6:	15 AM through 6:40			During Active Treatment	,.	
	AM. At 6:45 AM	1, client #3 joined her			observations, supervisors will		
	peers for the home's family style				assess direct support staff		
	1				interaction with clients and to		
	breakfast. At 7:05 AM, client #3 finished				provide hands on coaching an		
	_	fast and resumed pacing			training including but not limite	d	
		m, to the kitchen, to the			to assuring staff implement		
	living room area	and returned to the her			learning objectives and provide	e	
	bedroom.				frequent choices of activities.		
					Additionally, members of the Operations Team and the QID	D	
	Client #3's record	d was reviewed on			will conduct active treatment	'	
		PM. Client #3's ISP			observations on a weekly basis	s	
		ort Plan) dated 11/14/13	for the next 30 days, providing hands-on coaching and training				
	indicated client #	<sup>‡</sup> 3 had formal training			as needed to assure staff		
	objectives to con	nmunicate her wants,			implement learning objectives		
	needs and emotion	ons, participate in a			and implement behavior suppo	orts	
		, bathe her body, brush			and risk plans as written.		
	* *	y a penny, identify her			Additionally, The Operations		
					Team and QIDP will observe	khy	
		cipate in an activity,			active treatment sessions wee for the next 30 days.	Kiy	
	_	a meal and set her			ADDENDUM, 12/21/14: After		
	fork/spoon down	between bites of food.			one month, The Operations		
					Team and QIDP will observe		
	CS (Clinical Sup	pervisor) #2 was			active treatment sessions an	d	
	` .	1/6/14 at 2:15 PM. CS			review documentation no les	s	
		ve treatment should			than every two weeks. The		
					Operations Team will maintai	in	
	occui at every av	ailable opportunity.			no less than a twice monthly		
					presence in the home on an		
	9-3-4(a)				ongoing basis to assure that	.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet Page 22 of 39

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/12/2014		
	PROVIDER OR SUPPLIER		B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  4114 KNOLLTON RD  INDIANAPOLIS, IN 46228				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE		
	483.440(f)(3)(i) PROGRAM MONI The committee sh monitor individual manage inappropi programs that, in t committee, involve and rights. Based on record 1 of 4 sampled c HRC (Human Ri to review and ap psychotropic me for dental proced	TORING & CHANGE ould review, approve, and programs designed to riate behavior and other the opinion of the erisks to client protection review and interview for lients (#1), the facility's lights Committee) failed prove client #1's use of dication for pre-sedation lures.		the QIDP integrates, coordinates and monitors at aspects of the active treatm process. RESPONSIBLE PARTIES: QIDP, Residentia Manager, Team Leader, Directory Support Staff, Operations Teat  CORRECTION: The commits should review, approve, and monitor individual programs designed to manage inappropriate behavior and of programs that, in the opinion the committee, involve risks to client protection and rights. Specifically, the facility has located documentation of approval from the Human Rig Committee for Client #1's use	Il ent Il ct am Itee 12/12/2014  ther of o		
	11/6/14 at 1:00 PM. Client #1's dental summary progress report dated 3/13/14 indicated, "[Client #1] presents for recall with [staff #1] who reports that [client #1] has had 1 milligram Xanax			psychotropic medication for pre-sedation for dental procedures. A review of Hum Rights Committee documenta indicated that this deficient practice did not affect any			
	preoperatively. [ sedated." Client Record treatmen following:	Client #1] is nicely #1's Electronic Health t history indicated the		additional clients.  PREVENTION: The QIDP wi retrained regarding the need assure that the Human Rights Committee engages in a dialoreach decisions regarding restrictive programs for all clients.	to s og to		
	-11/9/09, "Valiui	m 10 milligrams 30		The QIDP, facility nurse and			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet

Page 23 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION IDE	ENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED	
	1	5G447	B. WING			11/12/	2014
			D. WIIW		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER				NOLLTON RD		
VOCA C	ORPORATION OF IND	DIANA			IAPOLIS, IN 46228		
(X4) ID	SUMMARY STAT	EMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		C IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	minutes prior to nex	xt visit to continue			Human Rights Committee liai	son	
	and complete debri	dement."			will each maintain copies of Human rights Committee		
					approval forms to assure the		
	-1/11/10, "[Client #	11 had not had the			ability to reproduce copies of		
	_	ms as prescribed. Will			HRC records for surveyors up		
		cale with Valium 10			request. The agency has		
					established a quarterly system	n of	
	milligrams 30 minu	ites prior to			internal audits that review all		
	treatment."				facility systems including, but		
					limited to, due process and process and process and process and process and process and process are a second process.	rior	
-4/12/10, "[Client #1] has had the Valium				written informed consent.  Administrative staff will condu	ıct		
10 milligrams as prescribed."				visits to the facility on a week			
					basis for the next 30 days.	',	
	-11/24/10, "Prescrip	otion for 10			ADDENDUM, 12/21/14: After		
	milligrams of Valiu				one month, The Operations		
		mi was presenteed.			Team and QIDP will observe	)	
	2/10/12 "Progorint	ion written out for			active treatment sessions a	nd	
	-3/19/12, "Prescript				review documentation no le	ss	
	Diazepam 10 millig	gram tablet."			than every two weeks. The	_	
					Operations Team will mainta		
	-4/9/12, "Treatment	postponed because			no less than a twice monthly		
	patient had not rece	ived Valium as			presence in the home on an ongoing basis, to assure the		
	ordered."				the QIDP integrates,	at	
					coordinates and monitors a	II	
	Client #1's consent	for medication form			aspects of the active treatm		
	dated 12/7/13 did n	ot indicate			process. The Program Mana	ger	
	documentation of H				will incorporate monitoring of		
		1's use of Valium 10			annual HRC approvals of		
					restrictive programs into the		
	milligrams or Xana	•			current tracking process.  RESPONSIBLE PARTIES:		
	sedation prior to de	niai procedures.			QIDP, Residential Manager,		
					Team Leader, Direct Support		
	CS (Clinical Superv	,			Staff, Operations Team		
	interviewed on 11/6	6/14 at 2:15 PM. CS					
	#2 indicated the facility's HRC should						
	review and approve	client #1's					
	psychotropic medic						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet Page 24 of 39

AND PLAN OF CORRECTION   DENTIFICATION NUMBER   15G447   S wind   11/12/2014	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA  (X4) ID SUMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION)  9-3-4(a)  W000263  483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.  Based on record review and interview for 2 of 4 sampled clients (#1 and #2), the facility's HRC (Human Rights Committee) failed to obtain the written informed consent of clients #1 and #2's guardians regarding the use of psychotropic medication for behavior management.  Findings include:  Findings include:  Findings regarding the use of psychotropic medication for behavior management.  Findings include:  Findings include:  Findings should:  Findings should insure that these programs are conducted only with the written informed consent of clients #1 and #2's guardian sessment, the interdisciplinary team has determined that only one individual (Client #2) needs to have limited access to soft drinks for documented health reasons. The modification of this right will be incorporated into Client #2's support plan based on physician recommendations and after the committee assures that written informed consent for client #1's has had I milligram Xanax preoperatively. [Client #1] is nicely sedated." Client #1's lectronic Health Record treatment history indicated the following:	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILDING	A RUIL DING 00 COMPLETED		
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA  (X4) ID PREFIX (EACH DIRECTENCY MUST BE PRECIDED BY PRUL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  9-3-4(a)  W000263 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.  Based on record review and interview for 2 of 4 sampled clients (# I and #2), the facility's HRC (Human Rights Committee) failed to obtain the written informed consent of clients # I and #2's guardians regarding the use of psychotropic medication for behavior management.  Findings include:  1. Client #1's record was reviewed on 11/6/14 at 1:00 PM. Client #1's dental summary progress report dated 3/13/14 indicated, "[Client #1] presents for recall with [staff #1] who reports that [client #1] has had I milligram Xanax preoperatively, [Client #1] is nicely sedated." Client #1's lectronic Health Record treatment history indicated the following:  STREET ADDRUSS. CITY, STATIE, ZIP CODE: 4114 KNOLLTON RD INDIANAPOLIS, IN 46228  ID PROFIT TAG  REQUITION TAG  PROFIT TAG  CORRECTION: The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.  Specifically and these processors are should insure that these programs are conducted only with the written informed consent of the client is a minor) or legal guardian.  Specifically and these programs are conducted only with the written informed consent of the client is a minor) or legal guardian.  Specifically and the season of the client is a minor) or legal guardian.  Specifically and these programs are conducted only with the written informed consent of the client is a minor) or legal guardian.  Specifically and these programs are conducted only with the written informed consent of the client is a minor) or legal guardian.  Specifically and the season of the client is a minor)			15G447			11/12/2014	
VOCA CORPORATION OF INDIANA  VOCA CORPORATION OF INDIANA  SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG  9-3-4(a)  W000263  483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, facility's HRC (Human Rights Committee) failed to obtain the written informed consent of clients #1 and #2's guardians regarding the use of psychotropic medication for behavior management.  Findings include:  Findings include:  Findings include:  Findings record was reviewed on 11/6/14 at 1:00 PM. Client #1's dental summary progress report dated 3/13/14 indicated, "[Client #1] presents for recall with [staff #1] who reports that [client #1] has had 1 milligram Xanax preoperatively. [Client #1] is nicely sedated." Client #1's Electronic Health Record treatment history indicated the following:  4114 KNOLLTON RD INDIANAPOLIS, N 46228  (XS)  **CORRECTION: The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.  Specifically to TClient #1, #2, #3 and #4, through assessment, the interdisciplinary team has determined that only one individual (Client #2) needs to have limited access to soft drinks for documented health reasons. The modification of this right will be incorporated into Client #2's guardian has been obtained. Through assessment, the team determined that this deficient practice affected 4 additional clients: #5, #6, #7 and #9. Access to soft drinks will not be limited for these individuals.				_	CADDRESS CITY STATE 7ID CODE		
VOCA CORPORATION OF INDIANA   INDIANAPOLIS, IN 46228	NAME OF F	PROVIDER OR SUPPLIE	R				
CX3   ID   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   CASCALL DEFICIENCY MIST BE PRECEDED BY FULL   PREFIX   TAG   CROSS-REPERSION OF THE APPROPRIATE   COMPLETION SHOULD BE CROSS-REPERSI	VOCA CO	ORPORATION OF	INDIANA				
PREFIX TAG  (LEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION)  9.3-4(a)  W000263  483.440ft)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.  Based on record review and interview for 2 of 4 sampled clients (#1 and #2), the facility's HRC (Human Rights Committee) failed to obtain the written informed consent of clients #1 and #2's guardians regarding the use of psychotropic medication for behavior management.  Findings include:  1. Client #1's record was reviewed on 11/6/14 at 1:00 PM. Client #1's dental summary progress report dated 3/13/14 indicated, "[Client #1] presents for recall with [staff #1] who reports that [client #1] has had 1 milligram Xanax preoperatively. [Client #1] is nicely sedated." Client #1's Electronic Health Record treatment history indicated the following:  CORRECTION: The committee should insure that these should insure that the should insure that these should insure that the should insure that the should insure that these should insure that these should insure that these should insure that these should insure that the should insure that these should insure that the should insure that these should insure that these should insure that the should insure that these should insure that the should insure that the should insure that the should insure that these should insure that the should insure that these should					1	(V5)	
PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.  Based on record review and interview for 2 of 4 sampled clients (#1 and #2), the facility's HRC (Human Rights Committee) failed to obtain the written informed consent of clients #1 and #2's guardians regarding the use of psychotropic medication for behavior management.  Findings include:  1. Client #1's record was reviewed on 11/6/14 at 1:00 PM. Client #1's dental summary progress report dated 3/13/14 indicated, "[Client #1] presents for recall with [staff #1] who reports that [client #1] has had 1 milligram Xanax preoperatively. [Client #1] is nicely sedated." Client #1's Electronic Health Record treatment history indicated the following:  CORRECTION: The committee should insure that these programs are conducted only with the written informed consent of the client, parents if the client is a minor) or legal guardian. Specifically for Clients #1, #2, #3 and #4, through assessment, the interdisciplinary team has determined that only one individual (Client #2) needs to have limited access to soft drinks for documented health reasons. The modification of this right will be incorporated in Client #2's support plan based on physician recommendations and after the committee assures that written informed consent from client #2's guardian has been obtained. Through assessment, the learn determined that this deficient practice affected 4 additional clients: #5, #6, #7 and #9. Access to soft drinks will not be limited for these individuals.						· ·	
9-3-4(a)  W000263  483 440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.  Based on record review and interview for 2 of 4 sampled clients (#1 and #2), the facility's HRC (Human Rights Committee) failed to obtain the written informed consent of clients #1 and #2's guardians regarding the use of psychotropic medication for behavior management.  Findings include:  1. Client #1's record was reviewed on 11/6/14 at 1:00 PM. Client #1's dental summary progress report dated 3/13/14 indicated, "[Client #1] presents for recall with [staff #1] who reports that [client #1] has had 1 milligram Xanax preoperatively. [Client #1] is nicely sedated." Client #1's Electronic Health Record treatment history indicated the following:		`			CROSS-REFERENCED TO THE APPROPRIA	AIE	
-11/9/09, "Valium 10 milligrams 30 staff will be retrained regarding the need to obtain prior written informed consent from guardians, and complete debridement"		9-3-4(a)  483.440(f)(3)(ii) PROGRAM MON The committee sh programs are corwitten informed oparents (if the clie guardian. Based on record 2 of 4 sampled of facility's HRC ( Committee) fail informed conser guardians regard psychotropic me management.  Findings include  1. Client #1's re 11/6/14 at 1:00 summary progre indicated, "[Clie with [staff #1] w #1] has had 1 m preoperatively. sedated." Client Record treatmen following:  -11/9/09, "Valid minutes prior to	ITORING & CHANGE nould insure that these nould insure that these noulcted only with the consent of the client, ent is a minor) or legal.  I review and interview for clients (#1 and #2), the Human Rights ed to obtain the written int of clients #1 and #2's ding the use of edication for behavior.  e:  cord was reviewed on PM. Client #1's dental ess report dated 3/13/14 ent #1] presents for recall who reports that [client illigram Xanax [Client #1] is nicely #1's Electronic Health int history indicated the		CORRECTION: The commits should insure that these programs are conducted only the written informed consent of the client, parents (if the client a minor) or legal guardian.  Specifically for Clients #1, #2, and #4, through assessment, interdisciplinary team has determined that only one individual (Client #2) needs to have limited access to soft dri for documented health reason. The modification of this right we be incorporated into Client #2 support plan based on physic recommendations and after the committee assures that writte informed consent from client #2 guardian has been obtained. Through assessment, the team determined that this deficient practice affected 4 additional clients: #5, #6, #7 and #9. Act to soft drinks will not be limited these individuals.  PREVENTION: Professional staff will be retrained regardin the need to obtain prior writter informed consent from guardian the result of the second consent from guardian the form guardian the for	tee 12/12/2014  with of t is #3 the   nks is. vill is ian iee in #2's im cess d for   g n	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet Page 25 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		15G447	B. WIN			11/12/2014
		<u>l</u>	D. WII		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIE	R			NOLLTON RD	
VOCA C	ORPORATION OF	INIDIANA			APOLIS, IN 46228	
VOCAC	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 40228	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
					representatives for all restrictive	ve
	-1/11/10 "[Clie	nt #1] had not had the			programs prior to implementat	
		grams as prescribed. Will			Retraining will focus on assuri	ng
		-			that the QIDP has a clear	
		ne scale with Valium 10			understanding of what specific	
	milligrams 30 m	ninutes prior to			constitutes a restrictive progra	m
	treatment."				and proper preparation for	
					presenting program modification guardians and other legal	JIIO
	-4/12/10 "[Clie	nt #1] has had the Valium			representatives. Prior to granti	ina
	10 milligrams as	-			approval to restrictive program	
	10 minigrams a	s preserioed.			the Human Rights Committee	
	-11/24/10, "Prescription for 10				obtain confirmation that the	
					facility has received prior writte	en
	milligrams of Valium was prescribed."				informed consent from guardia	
					or other legal representatives.	
	-3/19/12, "Prescription written out for				The agency has established a	
	Diazepam 10 m				quarterly system of internal au	
	Diazepain 10 iii	illigialli tabict.			that review all facility systems	
					including, but not limited to du	e
		nent postponed because			process and prior written	
	patient had not i	received Valium as			informed consent. Administrati	ive
	ordered."				staff will conduct visits to the facility on a weekly basis for the	20
					next 30 days. <b>ADDENDUM</b> ,	ie
	Client #1's ISD	(Individual Support Plan)			12/21/14: After one month, Th	ho l
		idicated client #1 had a			Operations Team and QIDP v	
					observe active treatment	****
	1	Client #1's record did not			sessions and review	
	indicate docume	entation of client #1's			documentation no less than	
	guardian's writte	en informed consent for			every two weeks. The	
	client #1's use o	f Valium 10 milligrams			Operations Team will mainta	in
		igram for sedation prior			no less than a twice monthly	
	to dental proced	•			presence in the home on an	
	lo dental proced	uics.			ongoing basis, to assure that	t
					the QIDP integrates,	
		cord was reviewed on			coordinates and monitors all	
	11/6/14 at 12:00	PM. Client #2's POF			aspects of the active treatme	nt
	(Physician's Ord	der Form) dated 9/19/14			process. RESPONSIBLE	
	1 ` •	#2 received Seroquel 100			PARTIES: QIDP, Residential	
		•			Manager, Team Leader, Direc	
	milligrams table	t (alixiciy) aliu	I		Support Staff Operations Tea	m I

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  15G447		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 11/12/2014	
	PROVIDER OR SUPPLIER		4114 K	ADDRESS, CITY, STATE, ZIP CODE NOLLTON RD JAPOLIS, IN 46228	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	daily for behavious #2's ISP dated 11 #2 had a legal guarecord did not in client #2's guard consent for the unclient #2's behavious CS (Clinical Suprinterviewed on 1 #2 indicated client their guardians's for the use psychological properties of the management 9-3-4(a)				
W000264	The committee sh make suggestions practices and progdrug usage, physic rooms, application stimuli, control of i protection of client other areas that the need to be address Based on observinterview for 4 of #2, #3 and #4), to constituted committee to the suggestion of the suggestio	TORING & CHANGE ould review, monitor and to the facility about its grams as they relate to cal restraints, time-out of painful or noxious nappropriate behavior, trights and funds, and any ne committee believes seed.  ation, record review and of 4 sampled clients (#1, the facility's specially mittee (Human Rights ed to review the facility's	W000264	CORRECTION:  The committee should review, monitor and make suggestions the facility about its practices a programs as they relate to druce.	nd

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet

Page 27 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	DING	00	COMPL	ETED
		15G447	A. BUII			11/12/	2014
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
		NIDIANA			NOLLTON RD		
VOCA CO	ORPORATION OF I	NDIANA		INDIAN	IAPOLIS, IN 46228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	practice of restri	cting clients #1, #2, #3			usage, physical restraints,		
	and #4 from sod				time-out rooms, application of		
	una // Trom sou				painful or noxious stimuli, contro	)/	
	T: 1: : 1 1				of inappropriate behavior,		
	Findings include				protection of client rights and		
					funds, and any other areas that		
	Observations we	re conducted at the			the committee believes need to		
	group home on 1	1/5/14 at 5:00 PM			be addressed. Specifically for		
	• •	I. At 5:30 PM, client #2			Clients #1, #2, #3 and #4,		
	•	group home's kitchen			through assessment, the		
					interdisciplinary team has		
		#1 was standing. Client			determined that only one		
	-	Pop." Staff #1 replied,			individual (Client #2) needs to		
	"Not tonight." C	lient #2 then returned to			have limited access to soft drinks	5	
	the living room a	area. At 5:45 PM, client			for documented health reasons.		
	#8 returned to th	e group home from an			The modification of this right will		
		Samily. Client #8 had a			be incorporated into Client #2's		
	•	th soda. Client #2			support plan based on physician		
	•				recommendations and after		
		at #8, stretched her hands			approval from the guardian and	_	
		up and made a 'pop'			the Human Rights Committee ha	S	
	sounding vocaliz	zation. Client #2 was			been obtained. Through	لہ	
	redirected and cl	ient #8 left the area. At			assessment, the team determine that this deficient practice	u	
	6:04 PM, client #	#2 stood in the hallway			affected 4 additional clients: #5,		
		hen area and the dining			#6, #7 and #9. Access to soft		
		top of the kitchen			drinks will not be limited for thes	:e	
	-	•			individuals.		
		op of the kitchen cabinet			arriadaior		
		rup of soda. Client #2					
	pointed toward to	he cup and made 'pop'					
	sounding vocaliz	zations.			PREVENTION:		
	   Staff #1 was inte	erviewed on 11/5/14 at			The QIDP has been retrained		
		1 stated, "They only get			regarding the need to assure		
					restrictive measures are		
		hat's when we go out to			implemented only when an		
	eat."				assessed need has been		
					identified and informed consent		
	CS #2 (Clinical S	Supervisor) was			has been obtained. The		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet Page 28 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G447	B. WIN			11/12/	2014
NAME OF I			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C.		4114 KI	NOLLTON RD		
VOCA C	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
		1/6/14 at 2:15 PM. CS			Governing Body has added an		
	#2 indicated clients #1, #2, #3 and #4				additional layer of supervision at the facility to assist the QIDP wit		
	should have diet soda if they choose.				focusing on support plan	''	
					development and monitoring,		
	1. Client #1's red	cord was reviewed on			including but not limited to		
	11/6/14 at 1:00 I	PM. Client #1's record			assessing client's need for		
	did not indicate	documentation of HRC			restrictive programs and their		
	review of the fac	cility's practice of			ability to give informed consent.		
	restricting client #1 from soda.				Members of the Operations Team	n	
					will review facility support documents no less than monthly		
	2. Client #2's red	cord was reviewed on			to assure that accurate informed		
		AM. Client #2's record			consent assessments are in place		
		documentation of HRC			and that prior written informed		
		cility's practice of			consent is obtained for all		
	restricting client				restrictive programs.		
	restricting enem	#1 Hom soua.					
	3. Client #3's red	cord was reviewed on					
	11/6/14 at 12:00	PM. Client #3's record			RESPONSIBLE PARTIES:		
		documentation of HRC			QIDP, Residential Manager,		
		cility's practice of			Team Leader, Direct Support Staff, Operations Team		
	restricting client				Stair, Operations Team		
	l restricting enem	III II					
	4. Client #4's red	cord was reviewed on					
	11/6/14 at 11:13	AM. Client #4's record					
	did not indicate	documentation of HRC					
		cility's practice of					
	restricting client	* *					
	Client #4 was in	terviewed on 11/10/14 at					
		asked if she was able to					
		r group home, client #4					
		ometimes. We had some					
	· ·	e don't get it too often."					
	uns weekend. W	e don't get it too onten.					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		15G447	B. WIN			11/12/	2014
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	BROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	9-3-4(a)  483.450(e)(2) DRUG USAGE Drugs used for colbehavior must be part of the client's that is directed spereduction of and ebehaviors for which Based on record 1 of 4 sampled controlling medifailed to ensure of treatment programmeduction.  Findings include  Client #1's record 11/6/14 at 1:00 From summary progressindicated, "[Client with [staff #1] which with [staff #	Introl of inappropriate used only as an integral individual program plan ecifically towards the ventual elimination of the th the drugs are employed. review and interview for lients on behavior cations (#1), the facility elient #1 had an active m with a plan of  d was reviewed on PM. Client #1's dental ess report dated 3/13/14 ent #1] presents for recall tho reports that [client lligram Xanax Client #1] is nicely #1's Electronic Health thistory indicated the  m 10 milligrams 30 enext visit to continue	W0		CROSS-REFERENCED TO THE APPROPRIAT	<i>e</i>	
	and complete del	pridement."			The QIDP has been retrained		
					regarding the need to incorporate	e	
	-1/11/10, "[Clien	t #1] had not had the			goals to reduce and eventually		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet

Page 30 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DI III	LDING	00	COMPLETED
		15G447	B. WIN			11/12/2014
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER					
VOCA 60		INIDIANIA			NOLLTON RD	
VOCA CO	ORPORATION OF I	INDIANA		INDIAN	APOLIS, IN 46228	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Valium 10 millig	grams as prescribed. Will			eliminate the use of behavior	
		e scale with Valium 10			controlling medications into	
	milligrams 30 m				support plans whenever such	
	_	mutes prior to			medications are prescribed. The	
	treatment."				Governing Body has added an	
					additional layer of supervision at	
	-4/12/10, "[Clien	nt #1] has had the Valium			the facility to assist the QIDP wit	h
	10 milligrams as prescribed."				focusing on support plan	
		-			development and monitoring,	
	-11/24/10, "Preso	cription for 10			including but not limited to	
	-	•			assessing developmental and	
	minigrams of va	alium was prescribed."			behavioral needs. Additionally,	
					members of the Operations Tean	n
	-3/19/12, "Presci	ription written out for			will review facility Behavior	
	Diazepam 10 mi	lligram tablet."			Support Plans no less than	
	_				monthly and to assure plans for	
	_4/9/12 "Treatm	ent postponed because			the reduction and eventual	
		eceived Valium as			elimination of behavior controllin	g
	•	eceived validili as			medications are included.	
	ordered."					
	Client #1's BSP	(Behavior Support Plan)			RESPONSIBLE PARTIES:	
	dated 12/7/13 did	d not indicate client #1's			QIDP, Residential Manager,	
	use of Valium 10	) milligrams or Xanax 1			Team Leader, Direct Support	
		e-sedation for dental			Staff, Operations Team	
					· •	
	*	nt #1's BSP did not				
		ntation of an active				
	treatment plan to	reduce client #1's need				
	for pre-sedation	for dental procedures.				
	CS (Clinical Sup	pervisor) #2 was				
		1/6/14 at 2:15 PM. CS				
		use of psychotropic				
		anage client behavior				
	should be includ	ed in the client's BSP.				
	9-3-5(a)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet Page 31 of 39

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
AND PLAIN	OF CORRECTION	15G447	A. BUII		00	11/12/	
		100771	B. WIN			1 1/ 12/	<u> </u>
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE NOLLTON RD		
VOCA C	ORPORATION OF I	INDIANA			APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000331	services in accord Based on record 3 of 4 sampled c the facility's nurs met the health no #4.  Findings include  1. Client #1's rec 11/6/14 at 1:00 F (Primary Care Pl 2/10/14 indicated gynecologist la (Complete Blood differential. Labe Gynecologist sug Client #1's PCP indicated client # "Make appointm for high platelets not indicate docubeing seen/evalu regarding her hig recommended or correspondence.  2. Client #2's rec 11/6/14 at 9:36 A	ance with their needs. review and interview for lients (#1, #2 and #4), sing services failed to eds of clients #1, #2 and  ecord was reviewed on PM. Client #1's PCP hysician) fax form dated d, "[Client #1] went to abs were drawn CBC d Count) with so found to be abnormal. Eggested fax results." fax dated 2/10/14 #1's PCP's response was eent with Hematologist s." Client #1's record did amentation of client #1 ated by a Hematologist	WO	00331	CORRECTION: The facility must provide clients with nurse services in accordance with the needs. Specifically: Overdue later for Clients #1, #2 and #4 will be collected and the results forwarded to their doctor's as ordered. A review of medical documentation indicated that the deficient practice also affected clients #6 and #8. Therefore required labs for these additional clients will be collected and the results forwarded to their doctor as well. PREVENTION: The Nurse Manager will assist the facility nurse and direct suppoint medical coach with tracking routine appointments and labtests to assure they occur as recommended. Additionally, Operations Team members including the Nurse Manager will assist the sessions, no less than weekly the next 30 days. ADDENDUM 12/21/14: After one month, Ti Operations Team and QIDP wobserve active treatment sessions and review documentation no less than every two weeks. The Operations Team will maintano less than a twice monthly presence in the home on an	eir abs abs ae this l al e or's t for he vill	12/12/2014

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G447	B. WIN			11/12/2014
NAME OF P	PROVIDER OR SUPPLIER	-			ADDRESS, CITY, STATE, ZIP CODE	
					NOLLTON RD	
VOCA CO	ORPORATION OF I	INDIANA		INDIAN	APOLIS, IN 46228	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		#2's Depakote (seizures)			ongoing basis, to assure medical follow-up and lab	
		checked every 2 months			testing occurrs as	
		ucose) should be			recommended.	
	1	months. Client #2's			RESPONSIBLE PARTIES:	
	Laboratory Repo	ort form(s) indicated the			QIDP, Residential Manager,	
	following:				Team Leader, Direct Support	
					Staff, Health Services Team, Operations Team	
	-10/16/13: Valpr	roic Acid			Operations realli	
	-3/27/14: CBC and CMP (Complete					
	Metabolic Panel).					
	-6/7/14: Glucose and Valproic Acid					
	-10/22/14: included glucose with no					
	documentation o	of Valproic Acid.				
		•				
	Client #2's recor	d did not indicate				
	documentation o	of client #2's Depakote				
	levels being ched	cked every 2 months or				
		C levels being checked				
	every three mont	•				
	j					
	3. Client #4's rec	cord was reviewed on				
	11/6/14 at 11:13	AM. Client #4's POF				
		dicated, "HgbA1C				
		3 months." Client #4's				
		Nursing Assessment)				
		ough 12/31/13 indicated				
		bA1C testing completed				
		1/4/13. Client #4's QNA				
		ough 11/5/14 indicated				
		AC testing had been				
		20/14 and 6/16/14. Client				
	1	IRHP (Comprehensive				
		h Plan) dated 10/17/14				
	_	Nurse will assure that				
	muicaicu, (3.) I	ruise will assure that				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I8FZ11

Facility ID: 000961

If continuation sheet

Page 33 of 39

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G447	B. WING		11/12/2014
NAME OF D	ROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF F	NO VIDER OR SUFFLIER			NOLLTON RD	
	ORPORATION OF I			IAPOLIS, IN 46228	<u>,                                      </u>
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCT)	DATE
	HgbA1C is obtai	med quarterry.			
	RN (Registered 1	Nurse) #1 was			
	, ,	1/6/14 at 2:30 PM. RN			
		nt #1's PCP had changed			
		o longer accepting			
	•	s. RN #1 indicated client			
	#1 would be seen				
on 12/3/14 and would be assessed to determine if a referral for a hematologist					
was still needed. RN #1 indicated client					
	#1 had not been seen by a hematologist.				
		laboratory orders should			
	-	as indicated on each			
	clients Physician	's Orders Form.			
	0.0.663				
	9-3-6(a)				
W000356	483.460(g)(2)				
	COMPREHENSIV	E DENTAL TREATMENT			
	,	nsure comprehensive			
		ervices that include dental elief of pain and infections,			
		n, and maintenance of			
	dental health.	,			
	Based on record	review and interview for	W000356		12/12/2014
	1 of 4 sampled c	lients (#2), the facility		CORRECTION:	
	failed to ensure of	client #2 received dental		The facility must ensure	
	treatment service	es.		The facility must ensure comprehensive dental treatment	<i>,</i>
				services that include dental care	
	Findings include	:		needed for relief of pain and	
				infections, restoration of teeth,	
	Client #2's record	d was reviewed on		and maintenance of dental	
	11/6/14 at 9:36 A	AM. Client #2's record		health. Specifically, the facility will assist Client #2 with receivir	ng
	did not indicate of	documentation of dental		recommended dental follow-up.	9

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet

Page 34 of 39

STATEMEN	T OF DEFICIENCIES	ES X1) PROVIDER/SUPPLIER/CLIA X2) I		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	INC	00	COMPLE	TED	
		15G447	B. WING	ING		11/12/2	2014	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIE	ER			NOLLTON RD			
VOCA C	ORPORATION OF	INDIANA			APOLIS, IN 46228			
VOCAC	ORFORATION OF	INDIANA		INDIAN	APOLIS, IN 40228			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	examination or	maintenance services			An audit conducted by the			
	being provided	to ensure client #2's			administrative team determined			
	dental health.				that this deficient practice also			
					affected Client #8. Therefore the	9		
	DNI (D	NI			facility will also assist Client #8			
	RN (Registered				with receiving recommended			
		11/6/14 at 2:30 PM. RN			dental follow-up.			
	#1 indicated cli	ent #2 should receive						
	dental examinat	tions and maintenance						
	services to ensu	re her dental health.			DDEVENTION.			
					PREVENTION:			
	9-3-6(a)				The Nurse Manager will assist th	ا م		
	9-3-0(a)				facility nurse and direct support			
					medical coach with tracking			
					routine dental appointments and			
					follow-ups to assure they occur	' I		
					as recommended. Additionally,			
					Operations Team members			
					including the Nurse Manager will			
					review medical documentation	·		
					while auditing active treatment			
					sessions, twice monthly for the			
					next 90 days to dental			
					appointments occur as			
					recommended. After three			
					months the administrative team			
					will evaluate the ongoing suppor	t I		
					needs of the facility with the goa			
					of reducing gradually the			
					administrative presence in the			
					home to no less than monthly.			
					,			
					RESPONSIBLE PARTIES:			
					QIDP, Residential Manager,			
					Team Leader, Direct Support			
					Staff, Health Services Team,			
					Operations Team			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet Page 35 of 39

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DINC	00	COMPL	ETED
		15G447	A. BUII B. WIN			11/12/	2014
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t .			NOLLTON RD		
VOCA CO	ORPORATION OF I	ΙΝΠΙΔΝΔ			IAPOLIS, IN 46228		
					1		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000474	483.480(b)(2)(iii) MEAL SERVICES						
		ved in a form consistent					
		ental level of the client.					
		ation, record review and	WO	00474	CORRECTION: Food must b	e	12/12/2014
		of 4 sampled clients (#2),			served in a form consistent with the developmental level of the		
		to implement client #2's					
	1	$\pi$ to implement ellent $\pi$ 2 s			client. Specifically, all facility s	taff	
	dietary orders.				will be formally retrained	ii a al	
					regarding preparation of modif texture diets, including but not		
	Findings include	:			limited to Client #2's modified		
					texture diet. A review of dietar	v	
	RM (Resident M	Ianager) #1 was			recommendations indicated th		
	interviewed on 11/5/14 at 5:53 PM.				deficient practice affected one		
	When asked whi	ch clients had			additional individual –Client #	-	
	specialized diet	orders, i.e. mechanical			Staff will also be trained towar	d	
	•	ek liquids, RM #1 stated,			proper implementation of this	ON.	
		echanical soft. Everyone			prescribed diet. PREVENTION The Residential Manager will to		
		Client #6] is the only			expected to observe no less th		
		enent #0] is the only			one morning and one evening		
	one."				active treatment session per		
					week and the Team Leader wi	II	
		ere conducted at the			be required to observe and		
	group home on 1	1/5/14 from 5:00 PM			participate in active treatment		
	through 6:15 PM	I. At 6:04 PM, client #2			sessions on varied shifts no le than five times per week. The	SS	
	participated in th	ne group home's family			QIDP will also maintain an		
	style evening me	eal. Client #2 ate pizza			ongoing presence at the facilit	y.	
	and salad. Client	#2's food was not			During Active Treatment	•	
	chopped or mech				observations, supervisors will		
	onoppou or moor				assess direct support staff		
	Client #2's recor	d was reviewed on			interaction with clients and to	d	
					provide hands on coaching an training including but not limite		
		AM. Client #2's Record			to assuring staff implement die		
	` ′	Form dated 6/21/12			and dining plans as ordered.		
	indicated client #				Additionally, members of the		
		diet to prevent choking.			Operations Team and the QID	Р	
	Client #2's Comp	prehensive High Risk			will conduct active treatment		
	Health Plan (CH	RHP) dated 7/7/14			observations on a weekly basi	S	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet

Page 36 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIWINDING	00	COMPLETED
		15G447	A. BUILDING		11/12/2014
			B. WING	ADDRESS SITY STATE TIP SODE	
NAME OF P	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
VOCA C	ORPORATION OF	INIDIANA		NOLLTON RD	
VOCAC	JRPORATION OF	INDIANA	INDIAN	NAPOLIS, IN 46228	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	indicated, "Follo	ow mechanical soft with		for the next 30 days, to assure	
	thin liquids 5 m	illiliter control flow cup		staff implement diets and dinir	•
guidelines at all times."			plans as ordered. ADDENDU		
	C			12/21/14: After one month, T	
	CS (Clinical Su	pervisor) #2 was		Operations Team and QIDP vobserve active treatment	VIII
	` '	•		sessions and review	
		11/6/14 at 2:15 PM. CS		documentation no less than	
		ent #2's dietary orders		every two weeks. The	
	should be imple	mented by staff.		Operations Team will mainta	in
	9-3-8(a)			no less than a twice monthly	
				presence in the home on an	
				ongoing basis, to assure tha	t
				the QIDP integrates,	
				coordinates and monitors all	
				aspects of the active treatme	ent
				process. RESPONSIBLE	
				PARTIES: QIDP, Residential	
				Manager, Team Leader, Direct	
				Support Staff, Operations Tea	m
W009999					
VV009999					
	State Findings		W009999		12/12/2014
	State Findings		W 009999	CORRECTION:	12/12/2014
	m 0.11 · ·				
	_	Community Residential		The residential provider shall	
	Facilities for Pe	rsons with		report the following	
	Developmental	Disabilities rule was not		circumstances to the division by	
	met.			telephone no later than the first	
				business day followed by writter	,
	460 IAC 9-3-1 (	Governing Body		summaries as requested by	
		ial provider shall report		division (15) A fall resulting in	
		_		injury, regardless of the severity	,
	_	rcumstances to the		of the injury. Specifically, the	
		phone no later than the		Residential Manager will be	
		y followed by written		retrained regarding requirement	S
	summaries as re	equested by division (15)		for reporting incidents to the	
	A fall resulting	in injury, regardless of		Indiana Bureau of Developmenta	31
	the severity of the			Disability Services, Bureau of	
			1	Quality Improvement Services	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet Page 37 of 39

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/12/2014		
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228				
(X4) ID PREFIX TAG	This state rule weby:  Based on record 1 of 2 falls with facility failed to with injury to the Developmental 1 within 24 hours law.  Findings include The facility's BI Developmental 1 reports, IRs (Inclinvestigations we at 2:18 PM. The		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRING DEFICIENCY)  and Adult Protective Services.  PREVENTION:  Supervisory staff will review all facility documentation to assumincidents are reported as required. The governing body hadded an additional layer of supervision at the facility which will enhance oversight of the incident reporting process. Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility Residential Manager or on-call supervisor as appropriat to assure incidents are reported.	e nas		
	-IR dated 8/24/14 indicated, "[Client #6] yelled for staff to help (sic) Upon arrival staff (sic) discovered [client #6] on her stomach on in her room. [Client #6] told staff she was trying to get in her wheelchair. [Client #6] has a rug burn above her right eye."  -The review did not indicate documentation of client #6's 8/24/14 fall with injury was reported to the BDDS.  CS (Clinical Supervisor) #1 was			to state agencies as required. If, through investigation, administrators discover that a Residential Manager has failed to report incidents to state agencies as required the governing body will administer written corrective action up to and including termination of employment.  RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	to des vee		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet Page 38 of 39

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/31/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CONSTRUCT A. BUILDING B. WING		00	(X3) DATE SURVEY  COMPLETED  11/12/2014		
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION	
TAG	REGULATORY OR	RY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	#1 indicated falls	1/5/14 at 2:15 PM. CS s with injury should be DDS within 24 hours of e incident.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

18FZ11

Facility ID: 000961

If continuation sheet

Page 39 of 39